



The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. **NOTE: Information about the cost of this plan (called the premium) will be provided separately.**

This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, call 800-332-0741. For general definitions of common terms, such as **allowed amount**, **balance billing**, **coinsurance**, **copayment**, **deductible**, **provider**, or other underlined terms see the Glossary. You can view the Glossary at [MedMutual.com/SBC](http://MedMutual.com/SBC) or call 800-332-0741 to request a copy.

Important Questions	Answers	Why This Matters:
<p>What is the overall <b>deductible</b>?</p>	<p><b>\$3,300</b>/single, <b>\$6,600</b>/family Network  <b>\$6,600</b>/single, <b>\$13,200</b>/family                      Non-Network</p>	<p>Generally, you must pay all of the costs from providers up to the <b>deductible</b> amount before this <b>plan</b> begins to pay. If you have other family members on the <b>plan</b>, each family member must meet their own individual <b>deductible</b> until the total amount of <b>deductible</b> expenses paid by all family members meets the overall family <b>deductible</b>.</p>
<p>Are there services covered before you meet your <b>deductible</b>?</p>	<p><b>Yes. Certain preventive care and all services with copayments are covered and paid by the plan before you meet your deductible.</b></p>	<p>This <b>plan</b> covers some items and services even if you haven't yet met the <b>deductible</b> amount. But a <b>copayment</b> or <b>coinsurance</b> may apply. For example, this <b>plan</b> covers certain <b>preventive services</b> without <b>cost-sharing</b> and before you meet your <b>deductible</b>. See a list of covered <b>preventive services</b> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a>.</p>
<p>Are there other <b>deductibles</b> for specific services?</p>	<p>No</p>	<p>You don't have to meet <b>deductibles</b> for specific services.</p>
<p>What is the <b>out-of-pocket limit</b> for this <b>plan</b>?</p>	<p><b>\$5,900</b>/single, <b>\$11,800</b>/family Network  <b>\$11,800</b>/single, <b>\$23,600</b>/family                      Non-Network</p>	<p>The <b>out-of-pocket limit</b> is the most you could pay in a year for covered services. If you have other family members in this <b>plan</b>, they have to meet their own <b>out-of-pocket limits</b> until the overall family <b>out-of-pocket limit</b> has been met.</p>
<p>What is not included in the <b>out-of-pocket limit</b>?</p>	<p>Certain <b>specialty drugs</b>, <b>premiums</b>, <b>balance-billed charges</b> and health care this <b>plan</b> doesn't cover.</p>	<p>Even though you pay these expenses, they don't count toward the <b>out-of-pocket limit</b>.</p>
<p>Will you pay less if you use a <b>network provider</b>?</p>	<p>Yes. See <a href="http://MedMutual.com/SBC">MedMutual.com/SBC</a> or call 800-332-0741 for a list of participating providers.</p>	<p>This <b>plan</b> uses a <b>provider network</b>. You will pay less if you use a <b>provider</b> in the <b>plan's network</b>. You will pay the most if you use an <b>out-of-network provider</b>, and you might receive a bill from a <b>provider</b> for the difference between the <b>provider's</b> charge and what your <b>plan</b> pays (<b>balance billing</b>). Be aware your <b>network provider</b> might use an <b>out-of-network provider</b> for some services (such as lab work). Check with your <b>provider</b> before you get services.</p>
<p>Do you need a <b>referral</b> to see a <b>specialist</b>?</p>	<p>No</p>	<p>You can see the <b>specialist</b> you choose without a <b>referral</b>.</p>



All **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies. Services with **copayments** are covered before you meet your **deductible**, unless otherwise specified.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	10% <u>coinsurance</u>	40% <u>coinsurance</u>	None
	Specialist visit	10% <u>coinsurance</u>	40% <u>coinsurance</u>	None
	Preventive care/ screening/ immunization	No charge	40% <u>coinsurance</u>	You may have to pay for services that aren't <u>preventive</u> . Ask your provider if the services you need are <u>preventive</u> . Then check what your <u>plan</u> will pay for.
If you have a test	Diagnostic test (x-ray)	10% <u>coinsurance</u>	40% <u>coinsurance</u>	None
	Diagnostic test (blood work)	10% <u>coinsurance</u>	40% <u>coinsurance</u>	None
	Imaging (CT/PET scans, MRIs)	10% <u>coinsurance</u>	40% <u>coinsurance</u>	None
If you need drugs to treat your illness or condition	Generic copay - retail Tier 1	\$20 after <u>deductible</u>	See Plan Documents for Details	Covers up to a 30-day supply.
	Generic copay - home delivery Tier 1	\$40 after <u>deductible</u>	See Plan Documents for Details	Covers up to a 90-day supply.
	Preferred brand copay - retail Tier 2	\$45 after <u>deductible</u>	See Plan Documents for Details	Covers up to a 30-day supply.
	Preferred brand copay - home delivery Tier 2	\$90 after <u>deductible</u>	See Plan Documents for Details	Covers up to a 90-day supply.
	Non-preferred brand copay - retail Tier 3	\$90 after <u>deductible</u>	See Plan Documents for Details	Covers up to a 30-day supply.
More information about prescription drug coverage is available at <a href="http://MedMutual.com/SBC">MedMutual.com/SBC</a>	Non-preferred brand copay - home delivery Tier 3	\$180 after <u>deductible</u>	See Plan Documents for Details	Covers up to a 90-day supply.
	Specialty drugs	20% up to \$125 max. of any available manufacturer-funded copay assistance	See Plan Documents for Details	Covers up to a 30-day supply.

[For more information about limitations and exceptions, see the plan or policy document at [MedMutual.com/SBC](http://MedMutual.com/SBC).]

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% <u>coinsurance</u>	40% <u>coinsurance</u>	None
	Physician/surgeon fees (Outpatient)	10% <u>coinsurance</u>	40% <u>coinsurance</u>	None
If you need immediate medical attention	Emergency room care	<b>Deductible</b> , \$85 copay/visit; 10% <u>coinsurance</u>	40% <u>coinsurance</u>	None
	Emergency medical transportation	10% <u>coinsurance</u>	40% <u>coinsurance</u>	None
	Urgent care	10% <u>coinsurance</u>	40% <u>coinsurance</u>	None
	Facility fee (e.g., hospital room)	10% <u>coinsurance</u>	40% <u>coinsurance</u>	None
If you have a hospital stay	Physician/ surgeon fee (inpatient)	10% <u>coinsurance</u>	40% <u>coinsurance</u>	None
	Outpatient services	Benefits paid based on corresponding medical benefits		None
If you need mental health, behavioral health, or substance abuse services	Inpatient services	Benefits paid based on corresponding medical benefits		None
	Office visits	No charge	40% <u>coinsurance</u>	Cost sharing does not apply to certain preventive services. Depending on the type of services, copay, <u>coinsurance</u> or <u>deductible</u> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
If you are pregnant	Childbirth/delivery professional services	10% <u>coinsurance</u>	40% <u>coinsurance</u>	None
	Childbirth/delivery facility services	10% <u>coinsurance</u>	40% <u>coinsurance</u>	None

[For more information about limitations and exceptions, see the plan or policy document at [MedMutual.com/SBC](http://MedMutual.com/SBC).]

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
If you need help recovering or have other special health needs	Home health care	10% coinsurance	40% coinsurance	None
	Rehabilitation services (Physical Therapy)	10% coinsurance	40% coinsurance	None
	Habilitation services (Occupational Therapy)	10% coinsurance	40% coinsurance	None
	Habilitation services (Speech Therapy)	10% coinsurance	40% coinsurance	None
	Skilled nursing care	10% coinsurance	40% coinsurance	None
	Durable medical equipment	10% coinsurance	40% coinsurance	None
	Hospice services	10% coinsurance	40% coinsurance	None
	Children's eye exam	No charge	40% coinsurance	None
	Children's glasses	Not Covered	Not Covered	Excluded Service
	Children's dental check-up	Not Covered	Not Covered	Excluded Service

[For more information about limitations and exceptions, see the [plan](#) or policy document at [MedMutual.com/SBC](#).]

## Excluded Services & Other Covered Services:

**Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)**

- Acupuncture
- Bariatric Surgery
- Children's dental check-up
- Children's glasses
- Cosmetic Surgery
- Dental Care (Adult)
- Fertility Treatment
- Long-Term Care
- Non-emergency care when traveling outside the U.S.
- Routine Eye Care (Adult)
- Routine Foot Care
- Weight Loss Programs

**Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)**

- Chiropractic Care
- Hearing Aids
- Private-Duty Nursing

**Your Rights to Continue Coverage:** There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 877-267-2323 x61565 or [ccio.cms.gov](http://ccio.cms.gov). Other coverage options may be available to you, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit [HealthCare.gov](http://HealthCare.gov) or call 800-318-2596.

**Your Grievance and Appeals Rights:** There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact your plan at 800-332-0741.

### Does this plan provide Minimum Essential Coverage? Yes.

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

### Does this plan meet Minimum Value Standards? Yes.

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

-----*To see examples of how this plan might cover costs for sample medical situations, see the next section*-----  
The coverage example numbers assume that the patient does not use an HRA or FSA. If you participate in an HRA or FSA and use it to pay for out-of-pocket expenses, then your costs may be lower.

[ For more information about limitations and exceptions, see the plan or policy document at [MedMutual.com/SBC](http://MedMutual.com/SBC).]

**About these Coverage Examples:**



**This is not a cost estimator.** Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

**Peg is Having a Baby**  
(9 months of in-network pre-natal care and a hospital delivery)

- **The plan's overall deductible** \$3,300
- **Specialist coinsurance** 10%
- **Hospital (facility) coinsurance** 10%
- **Other coinsurance** 10%

**This EXAMPLE event includes services like:**  
Specialist office visits (*prenatal care*)  
Childbirth/Delivery Professional Services  
Childbirth/Delivery Facility Services  
Diagnostic tests (*ultrasounds and blood work*)  
Specialist visit (*anesthesia*)

**Total Example Cost** \$12,700

**Managing Joe's Type 2 Diabetes**  
(a year of routine in-network care of a well-controlled condition)

- **The plan's overall deductible** \$3,300
- **Specialist coinsurance** 10%
- **Hospital (facility) coinsurance** 10%
- **Other coinsurance** 10%

**This EXAMPLE event includes services like:**  
Primary care physician office visits (*including disease education*)  
Diagnostic tests (*blood work*)  
Prescription drugs  
Durable medical equipment (*glucose meter*)

**Total Example Cost** \$5,600

**Mia's Simple Fracture**  
(in-network emergency room visit and follow up care)

- **The plan's overall deductible** \$3,300
- **Specialist coinsurance** 10%
- **Hospital (facility) coinsurance** 10%
- **Other coinsurance** 10%

**This EXAMPLE event includes services like:**  
Emergency room care (*including medical supplies*)  
Diagnostic test (*x-ray*)  
Durable medical equipment (*crutches*)  
Rehabilitation services (*physical therapy*)

**Total Example Cost** \$2,800

**In this example, Peg would pay:**

<i>Cost Sharing</i>	
Deductibles	\$3,300
Copayments	\$10
Coinsurance	\$900
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$4,270</b>

**In this example, Joe would pay:**

<i>Cost Sharing</i>	
Deductibles	\$3,300
Copayments	\$400
Coinsurance	\$10
<i>What isn't covered</i>	
Limits or exclusions	\$20
<b>The total Joe would pay is</b>	<b>\$3,730</b>

**In this example, Mia would pay:**

<i>Cost Sharing</i>	
Deductibles	\$2,700
Copayments	\$90
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$2,790</b>

Note: These numbers assume the patient does not participate in the plan's wellness program. If you participate in the plan's wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact: 800-332-0741.

The plan would be responsible for the other costs of these EXAMPLE covered services.

[For more information about limitations and exceptions, see the plan or policy document at [MedMutual.com/SBC](http://MedMutual.com/SBC).]



This document notifies individuals of how to seek assistance if they speak a language other than English.

**Spanish**

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-382-5729 (TTY: 711).

**Chinese**

注意: 如果您使用繁體中文, 您可以免費獲得語言援助服務。請致電 1-800-382-5729 (TTY: 711)。

**German**

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-382-5729 (TTY: 711).

**Arabic**

ملاحظة: إذا كنت تتحدث اللغة العربية، فإن خدمات المساعدة اللغوية متوفرة لك مجاناً. اتصل برقم 1-800-382-5729 (رقم هاتف الصم والبكم 711).

**Pennsylvania Dutch**

Wenn du Deutsch schwetzsch, kannscht du mitaus Koschde ebber gricke, ass dihr helft mit die englissh Schprooch. Ruf selli Nummer uff. Call 1-800-382-5729 (TTY: 711).

**Russian**

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-382-5729 (телефакс: 711).

**French**

ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-382-5729 (ATS: 711).

**Vietnamese**

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-382-5729 (TTY: 711).

**Navajo**

Díí baa akó nínízin: Díí saad bee yáńhítí go Dine Bizaad, saad bee áká'ánída áwo'déé, 't'áá jik'eh, éí ná hóíq, kojí' hódííłíníh 1-800-382-5729 (TTY: 711).

**Oromo**

XIYYEEFFANNAA: Afaan dubbattu Oromiffa, tajaajila gargaarsa afaanii, kanfattiidhaan ala, ni argama. Bilbilaa 1-800-382-5729 (TTY: 711).

**Korean**

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-382-5729 (TTY: 711)번으로 전화해 주십시오.

**Italian**

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-800-382-5729 (TTY: 711).

**Japanese**

注意事項: 日本語を話される場合、無料の言語支援をご利用いただけます。1-800-382-5729 (TTY: 711)まで、お電話にてご連絡ください。

**Dutch**

AANDACHT: Als u nederlands spreekt, kunt u gratis gebruikmaken van de taalkundige diensten. Bel 1-800-382-5729 (TTY: 711).

**Ukrainian**

УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером 1-800-382-5729 (телефакс: 711).

**Romanian**

ATENȚIE: Dacă vorbiți limba română, vă stau la dispoziție servicii de asistență lingvistică, gratuit. Sunați la 1-800-382-5729 (TTY: 711).

**Tagalog**

PAUNAWA: Kung nagsasalita ka ng Tagalog, maari kang gumamit ng mga serbisyong tulong sa wika nang walang bayad. Tumawag sa 1-800-382-5729 (TTY: 711).

**QUESTIONS ABOUT YOUR BENEFITS OR OTHER INQUIRIES ABOUT YOUR HEALTH INSURANCE SHOULD BE DIRECTED TO MEDICAL MUTUAL'S CUSTOMER CARE DEPARTMENT AT 1-800-382-5729.**

**Nondiscrimination Notice**

Medical Mutual of Ohio complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex in its operation of health programs and activities. Medical Mutual does not exclude people or treat them differently because of race, color, national origin, age, disability or sex in its operation of health programs and activities.

- Medical Mutual provides free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters, and written information in other formats (large print, audio, accessible electronic formats, etc.).
- Medical Mutual provides free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages.

**If you need these services or if you believe Medical Mutual failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, with respect to your health care benefits or services, you can submit a written complaint to the person listed below. Please include as much detail as possible in your written complaint to allow us to effectively research and respond.**

**Civil Rights Coordinator**

Medical Mutual of Ohio  
2060 East Ninth Street  
Cleveland, OH 44115-1355  
MZ: 01-10-1900

**Email:** [CivilRightsCoordinator@MedMutual.com](mailto:CivilRightsCoordinator@MedMutual.com)

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights.

- Electronically through the Office for Civil Rights Complaint Portal available at: [ocrportal.hhs.gov/ocr/portal/lobby.jsf](http://ocrportal.hhs.gov/ocr/portal/lobby.jsf)
- By mail at:  
U.S. Department of Health and Human Services  
200 Independence Avenue, SW Room 509F  
HHH Building  
Washington, DC 20201-0004
- By phone at:  
(800) 368-1019 (TDD: (800) 537-7697)
- Complaint forms are available at: [hhs.gov/ocr/office/file/index.html](http://hhs.gov/ocr/office/file/index.html)

Products marketed by Medical Mutual may be underwritten by one of its subsidiaries, such as Medical Health Insuring Corporation of Ohio or Consumers Life Insurance Company.